

CRAIG WESLEY RIMER AFFIDAVIT OF SERVICE

ATTACHMENT H

CRAIG WESLEY RIMER AFFIDAVIT OF SERVICE

DECEDENTS

NAME OF DECEDANT	DATE OF DEATH	PLACE OF DEATH
Rowan, Mary Jean	1/2/2015	Monroe County, New York
Brooks, Lynnette L.		
Billeb, Gregory	5/19/2019	Toulumne County, California
Billeb, James William		Washoe County, Nevada
Wallace, Karen A.		
Mendoza, Ann F.	12/6/2016	San Bernardino County, California
Mendoza, Ralph		Riverside County, California

COUNTY of SAN BERNARDINO

DEPARTMENT OF PUBLIC HEALTH

351 N. MT. VIEW AVENUE, SAN BERNARDINO, CALIFORNIA 92415-0010

CERTIFICATE OF DEATH

3201436012086

STATE FILE NUMBER		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEASED - FIRST (Given) ANN		2. MIDDLE FLORENCE	
3. LAST (Family) FREASE			
4. DATE OF BIRTH mm/dd/yy 1/1941		5. AGE Yrs 73	
6. UNDER ONE YEAR Months _____ Days _____ Hours _____ Minutes _____		7. UNDER 24 HOURS Hours _____ Minutes _____	
8. SEX F			
9. BIRTH STATE/FOREIGN COUNTRY ME		10. SOCIAL SECURITY NUMBER 6350	
11. EVER IN U.S. ARMED FORCES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK		12. MARITAL STATUS/SHIP at Time of Death MARRIED	
13. EDUCATION - Highest Level/Degree HS GRADUATE		14. WAS DECEASED HISPANIC/LATINO/SPANISH? If yes, see worksheet back <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
15. DECEASED'S RACE - Up to 3 races may be listed (see worksheet on back) WHITE		16. DATE OF DEATH mm/dd/yy 12/06/2014	
17. USUAL OCCUPATION - Type of work for most of life. DO NOT USE RETIRED OWNER		18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construct or, employment agency, etc.) BAR	
19. YEARS IN OCCUPATION 30			
20. DECEASED'S RESIDENCE (Street and number, or location) 15239 WILDFLOWER LANE			
21. CITY HELDENALE		22. COUNTY/PROVINCE SAN BERNARDINO	
23. ZIP CODE 92342		24. YEARS IN COUNTY 22	
25. STATE/FOREIGN COUNTRY CA			
26. INFORMANT'S NAME, RELATIONSHIP JACK FREASE, HUSBAND		27. INFORMANT'S MAILING ADDRESS (Street and number, or route, route number, city or town, state and zip) P.O. BOX 2066, HELDENALE, CA 92342	
28. NAME OF SURVIVING SPOUSE/SPOUSE-FIRST JACKIE		29. MIDDLE DEAN	
30. NAME OF FATHER/PARENT-FIRST EARL		31. LAST WALLACE	
32. NAME OF MOTHER/PARENT-FIRST MARY		33. MIDDLE RITA	
34. BIRTH STATE ME		35. LAST (BIRTH NAME) O'DONNELL	
36. DISPOSITION DATE mm/dd/yy 12/10/2014		37. PLACE OF FINAL DISPOSITION RES JACK FREASE 15239 WILDFLOWER LANE, HELDENALE, CA 92342	
38. TYPE OF DISPOSITION CR/RES		39. SIGNATURE OF EMBALMER ► NOT EMBALMED	
40. NAME OF FUNERAL ESTABLISHMENT AFFORDABLE CREMATIONS OF THE HIGH DESERT		41. LICENSE NUMBER FD2032	
42. SIGNATURE OF LOCAL REGISTRAR ► MAXWELL OHIKHUAKE, MD		43. LICENSE NUMBER 12/10/2014	
44. PLACE OF DEATH RESIDENCE HOSPICE		45. IF HOSPITAL, SPECIFY ONE <input type="checkbox"/> IN <input type="checkbox"/> OUT <input type="checkbox"/> USA <input type="checkbox"/> UK <input checked="" type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Other	
46. IF OTHER THAN HOSPITAL, SPECIFY ONE HELDENALE		47. DEATH REPORTED TO CORONER Coroner Death (At) MINS	
48. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location) SAN BERNARDINO 15239 WILDFLOWER LANE		49. DEATH REPORTED TO CORONER Coroner Death (At) MINS	
50. CAUSE OF DEATH IMMEDIATE CAUSE Cardiac Arrest		51. DEATH REPORTED TO CORONER Coroner Death (At) MINS	
52. SEQUELAE (If any condition existing at death which contributed to death) Cerebral Vascular Accident		53. DEATH REPORTED TO CORONER Coroner Death (At) MINS	
54. UNDERLYING CAUSE (Specify if any condition existing at death which resulted in death) Unspecified Essential Hypertension		55. DEATH REPORTED TO CORONER Coroner Death (At) MINS	
56. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 54 Cachexia		57. DEATH REPORTED TO CORONER Coroner Death (At) MINS	
58. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 54 OR 55? (If yes, list type of operation and date) NO		59. IF FEMALE, PREGNANT IN LAST YEAR <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK	
60. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED Deceased Attended Since Deceased Last Seen At:		61. SIGNATURE AND TITLE OF CERTIFIER ► SREEKANTH GANAPAVARAPU M.D.	
62. DATE mm/dd/yy 11/07/2014		63. LICENSE NUMBER A82967	
64. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE 16147 KAMANA ROAD, APPLE VALLEY, CA 92307		65. DATE mm/dd/yy 12/10/2014	
66. I CERTIFY THAT IN MY OPINION, DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED WATER OF DEATH <input type="checkbox"/> Nature <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Drowning <input type="checkbox"/> Poisoning <input type="checkbox"/> Other		67. INJURED AT WORK? <input type="checkbox"/> LS <input type="checkbox"/> NO <input type="checkbox"/> UNK	
68. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)		69. INJURY DATE mm/dd/yy 12/10/2014	
70. DATE mm/dd/yy 11/30/2014		71. HOUR (24 hours)	
72. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)			
73. LOCATION OF INJURY (Street and number, or location, and city, and zip)			
74. SIGNATURE OF CORONER / DEPUTY CORONER ►		75. DATE mm/dd/yy 12/10/2014	
76. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER		77. FAX AUTH.#	
78. STATE REGISTRAR A B C D E		79. CENSUS TRACT 0100102800078*	

CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA
COUNTY OF SAN BERNARDINO

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DATE ISSUED

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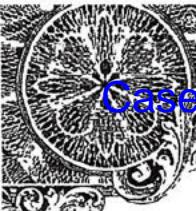
Maxwell Ohikhua
MAXWELL OHIKHUAKE, M.D.
COUNTY HEALTH OFFICER
REGISTRAR OF VITAL STATISTICS

PBNO/DR/10/11

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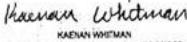
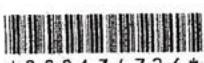
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RESIDENCE		REGISTERED DISTRICT 44	NEW YORK STATE DEPARTMENT OF HEALTH		STATE FILE NUMBER		
					3A. DATE OF DEATH MONTH DAY YEAR	3B. HOUR	
NCHS		MARY JEAN ROWAN	SEX MALE <input type="checkbox"/> 1	FEMALE <input checked="" type="checkbox"/> 2	01 02 2015	9:35 P M	
4C		4A PLACE OF DEATH (Check one) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> DOA <input type="checkbox"/> ER <input type="checkbox"/> HOSPITAL <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input checked="" type="checkbox"/> NURSING HOME <input type="checkbox"/> PRIVATE RESIDENCE <input checked="" type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> OTHER (Specify)	4D LOCALITY (Check one and specify) CITY VILLAGE TOWN		4B IF FACILITY, DATE ADMITTED MONTH DAY YEAR		
4G		4C NAME OF FACILITY (If not facility, give address) The Jewish Home of Rochester			4E COUNTY OF DEATH Monroe		
		4F MEDICAL RECORD NO 24617	4G WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) <input type="checkbox"/> NO <input checked="" type="checkbox"/> Yes XX Rochester General Hospital Rochester, Monroe, New York				
7A		5 DATE OF BIRTH MONTH DAY YEAR 1929 85 yrs	6A AGE IN YEARS months days	5B IF UNDER 1 YEAR ENTER hours minutes	6C IF UNDER 1 DAY ENTER hours minutes	7A CITY AND STATE OF BIRTH (If not USA, Country and Region/Province) Rochester, NY	7B IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH
7B		8 SERVED IN U.S. ARMED FORCES? (Specify years) <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> NO YES <input checked="" type="checkbox"/> XX 0 <input type="checkbox"/> 1	9 DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> C Yes, Puerto Rican <input type="checkbox"/> E Yes, Other Spanish/Hispanic/Latino (Specify)		10 DECEDENT'S RACE Check one or more races to indicate what the decedent considered himself or herself to be <input checked="" type="checkbox"/> White/Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> American Indian or Alaska Native (Specify) <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> S Other (Specify)		
25		11 DECEDENT'S EDUCATION Check the box that best describes the highest degree or level of school completed at the time of death <input type="checkbox"/> 1 5th grade <input type="checkbox"/> 2 9th-12th grade, no diploma <input type="checkbox"/> 3 High school graduate or GED <input checked="" type="checkbox"/> XX Some college credit, but no degree <input type="checkbox"/> 5 Associate's degree <input type="checkbox"/> 6 Bachelor's degree <input type="checkbox"/> 7 Master's degree <input type="checkbox"/> 8 Doctorate/Professional degree	12 SOCIAL SECURITY NUMBER 7544		13 MARITAL STATUS NEVER MARRIED <input type="checkbox"/> 1	14 SURVIVING SPOUSE Enter birth name of spouse if married or separated	
SI		15A USUAL OCCUPATION (Do not enter retired) Legal Secretary	15B KIND OF BUSINESS OR INDUSTRY Law		15C NAME AND LOCALITY OF COMPANY OR FIRM Underberg & Kessler Roch., NY		
30		16A RESIDENCE (State or Country if not USA) New York	16B County or Region/Province If not USA Monroe		16C LOCALITY (Check one and specify) CITY VILLAGE TOWN <input type="checkbox"/> XX Brighton		
31		16D STREET AND NUMBER OF RESIDENCE 2021 Winton Road South Rochester, New York	16E ZIP CODE 14618		16F IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, SPECIFY TOWN		
31B		17 BIRTH NAME OF FATHER / PARENT Paul	LAST Burke	18 BIRTH NAME OF MOTHER / PARENT Mary	19 FIRST MI LAST Guilfoyle		
32		19A NAME OF INFORMANT Terrance P. Rowan	19B MAILING ADDRESS (Include zip code) 194 Ingomar Drive Rochester, New York 14612		20C LOCATION (City or town and state) Rochester, New York		
33		20A 1 <input type="checkbox"/> BURIAL 2 <input checked="" type="checkbox"/> CREMATION 3 <input type="checkbox"/> REMOVAL MONTH DAY YEAR 6 <input type="checkbox"/> ENTOMBMENT 01 05 2015	20B PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION Mt. Hope Crematory		20C DATE ISSUED MONTH DAY YEAR 15 15 2015		
34		21A NAME AND ADDRESS OF FUNERAL HOME Farrell-Ryan Funeral Home 777 Long Pond Road Rochester, NY 14612	21B REGISTRATION NUMBER 00571		21C REGISTRATION NUMBER 13578		
35		22A NAME OF FUNERAL DIRECTOR Joseph G. Tomasso	22B SIGNATURE OF FUNERAL DIRECTOR Joseph G. Tomasso		22C REGISTRATION NUMBER 13578		
36		23A SIGNATURE OF REGISTRAR Mark L. Johnson	23B DATE ISSUED MONTH DAY YEAR 15 05 2015	24A BURIAL OR REMOVAL PERMIT ISSUED BY Mark L. Johnson	24B DATE ISSUED MONTH DAY YEAR 15 15 2015		
37		ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER					
38		25A. CERTIFICATION To the best of my knowledge, death occurred at the time, date and place and due to the causes stated Certifier's Name Karyn Leible					
39		License No Signature Address 2021 Winton Rd S Rochester 14618					
40		Month Day Year 04 01 2013					
41		Month Day Year 01 05 2015					
42		26A Attending physician attended deceased FROM 04 01 2013 TO 01 05 2015					
43		26B Deceased last seen alive by attending physician 01 05 2015					
44		26C Deceased pronounced dead ON 01 05 2015 AT 9:35 P M					
45		27 MANNER OF DEATH NATURAL CAUSE <input checked="" type="checkbox"/> ACCIDENT <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 HOMICIDE <input type="checkbox"/> 5 <input type="checkbox"/> 6 SUICIDE <input type="checkbox"/> 7 <input type="checkbox"/> 8 UNDETERMINED CIRCUMSTANCES PENDING INVESTIGATION					
46		28 WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES 29A AUTOPSY? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> REFUSED 29B IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES					
47		SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH					
48		CONFIDENTIAL					
49		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
50		30 DEATH WAS CAUSED BY (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C))					
51		For use by physician or institution NAME OF DECEASED May Jean Rowan DATE OF DEATH 9:35 AM TIME OF DEATH 1-2-2015					
52		CAUSE OF DEATH					

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 STATE OF CALIFORNIA CERTIFICATION OF VITAL RECORD		
OFFICE OF ASSESSOR - RECORDER COUNTY OF TUOLUMNE SONORA, CALIFORNIA		
CERTIFICATE OF DEATH <hr/> <p>3052019100236</p> <p><small>STATE FILE NUMBER</small></p> <p><small>LAST NAME, FIRST NAME, MIDDLE INITIAL, LAST NAME, MIDDLE INITIAL, LAST NAME GREGORY</small></p> <p><small>2. MIDDLE NAME PENN</small></p> <p><small>3. LAST NAME BILLEB</small></p> <p><small>4. DATE OF BIRTH (MONTH/DAY/ YEAR) 06/27/1952</small></p> <p><small>5. AGE AT DEATH 67</small></p> <p><small>6. SEX M</small></p> <p><small>7. BIRTH STATE/OTHER COUNTRY CA</small></p> <p><small>8. SOCIAL SECURITY NUMBER 1766</small></p> <p><small>9. 11. CIVIL STATUS MARRIED</small></p> <p><small>12. EDUCATION (High School Graduate) YES NO UNK</small></p> <p><small>13. HS GRADUATE YES NO CAUCASIAN</small></p> <p><small>14. OCCUPATION - Type of work or most skill (DO NOT USE PICTURES) SALES</small></p> <p><small>15. KIND OF BUSINESS IN INDUSTRY (e.g., grocery store, fast food restaurant, employment agency etc.) GRAPHIC ARTS</small></p> <p><small>16. YEARS IN OCCUPATION 26</small></p> <p><small>17. DECEASED'S RESIDENCE Street and number of location 20047 LONGVIEW STREET</small></p> <p><small>18. CITY GROVELAND</small></p> <p><small>19. COUNTY/PROVINCE TUOLUMNE</small></p> <p><small>20. ZIP CODE 95321</small></p> <p><small>21. YEARS ALONE 21</small></p> <p><small>22. LOCAL TIME OF DEATH 05/15/2019</small></p> <p><small>23. PLACE OF DEATH SCATTER AT SEA OFF THE COAST OF MARIN COUNTY, CA</small></p> <p><small>24. TYPE OF DISPOSITION CR/SEA</small></p> <p><small>25. SIGNATURE OF EMBALMER NOT EMBALMED</small></p> <p><small>26. SIGNATURE OF LOCAL REGISTRAR NEPTUNE SOCIETY OF NORTHERN CALIFORNIA FD1502 KAENAN S WHITMAN</small></p> <p><small>27. SIGNATURE OF HOSPITAL AVALON CARE CENTER-SONORA</small></p> <p><small>28. FACILITY ADDRESS WHERE FOUND Street and number of location TUOLUMNE 19929 GREENLEY RD</small></p> <p><small>29. CITY SONORA</small></p> <p><small>30. PLACE OF DEATH DEATH OCCURRED ON THE SAME DAY AS THE PLACEMENT INTO THE FACILITY</small></p> <p><small>31. CAUSE OF DEATH IMMEDIATE CAUSE: IN END STAGE LIVER FAILURE</small></p> <p><small>32. DEATH REPORTED TO CORONER NO</small></p> <p><small>33. PLACES OF PLACEMENT 183 S FAIRVIEW LN STE C, SONORA, CA 95370</small></p> <p><small>34. DESCRIPTION OF PLACEMENT (Specify Room Number)</small></p> <p><small>35. LOCATION OF PLACEMENT (Street and number of location, and city, and zip)</small></p> <p><small>36. SIGNATURE OF CORONER / DEPUTY CORONER Matthew Lincoln Personius, M.D.</small></p> <p><small>37. DATE OF DEATH 05/10/2019</small></p> <p><small>38. TITLE, NAME, TITLE OF CORONER / DEPUTY CORONER Matthew Lincoln Personius, M.D.</small></p> <p><small>39. STATE REGISTRAR A B C D E</small></p> <p><small>40. DATE ISSUED 5/28/2019</small></p> <p><small>41. FAX AUTH.F GLENCOE TRACT 06001004208302</small></p>		
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